

BEFORE THE DEPARTMENT OF LABOR AND INDUSTRY
STATE OF MONTANA

In the matter of the proposed amendment)	NOTICE OF PUBLIC HEARING
of ARM 24.29.207, 24.29.1404,)	ON PROPOSED AMENDMENT
24.29.1426, 24.29.1504, 24.29.1521,)	AND ADOPTION
24.29.1532, 24.29.1536, 24.29.1541,)	
24.29.1551, 24.29.1561, 24.29.1566,)	
24.29.1572, 24.29.1573, 24.29.1582,)	
24.29.1583, and 24.29.1584, and the)	
proposed adoption of NEW RULES I)	
through VIII, related to the workers')	
compensation medical fee schedule for)	
nonfacilities, the workers' compensation)	
medical treatment and utilization guidelines)	
for occupational therapists, physical)	
therapists, and chiropractors, and other)	
matters related to workers' compensation)	
claims)	

TO: All Concerned Persons

1. On September 28, 2007, at 10:00 a.m., the Department of Labor and Industry (department) will hold a public hearing to be held in the DPHHS Auditorium, 111 North Sanders, Helena, Montana to consider the proposed amendment and adoption of the above-stated rules.

2. The department will make reasonable accommodations for persons with disabilities who wish to participate in this public hearing or need an alternative accessible format of this notice. If you require an accommodation, contact the department no later than 5:00 p.m., on September 21, 2007, to advise us of the nature of the accommodation that you need. Please contact the Workers' Compensation Regulations Bureau, Employment Relations Division, Department of Labor and Industry, Attn: Jeanne Johns, P.O. Box 8011, Helena, MT 59624-8011; telephone (406) 444-7710; fax (406) 444-3465; TDD (406) 444-5549; or e-mail jjohns@mt.gov.

3. GENERAL STATEMENT OF REASONABLE NECESSITY: The 2007 Legislature passed Chap. 330, L. 2007 (HB 738) which set a cap on the conversion factors the Department of Labor and Industry may set for reimbursement rates for medical services provided to injured workers. The legislation also changed the relative value unit publication that the conversion factor is to be applied to. Formerly, the department by administrative rule followed the publication entitled Relative Values for Physicians (RVP). The legislation now requires that the Resource-Based Relative Value Scale (RBRVS) be used to establish reimbursement rates for medical treatment provided to injured workers. The RBRVS is the basis for reimbursement rates for the major public and private medical insurance payers in

Montana including Medicare, Medicaid, and Blue Cross/Blue Shield of Montana. The majority of other state workers' compensation systems that have medical fee schedules also base them on the RBRVS system. Conversion to an RBRVS reimbursement system will provide efficiency and convenience for both providers and payers who already use the RBRVS as the basis for billing the major public and private payers in Montana. These proposed amendments and new rules change the administrative rules to implement and conform to the statutory changes contained in HB 738.

The department believes that there is reasonable necessity to amend, rather than repeal, the existing fee schedule rules despite the fact that the rules will be superseded by NEW RULES I through VIII for services provided on or after January 1, 2008. The department bases that belief upon input from the Montana State Fund, which notes that disputes over medical services and fees payable sometimes linger for years, and that payment of old bills can be handled more promptly when the applicable rules are still "on the books." The department has considered but rejected the alternative of repealing the soon-to-be obsolete rules, based upon the input from the Montana State Fund.

The department believes that adoption of a new set of rules (NEW RULES I through VIII) tied to the RBRVS system will be less confusing than merely amending the existing rules to incorporate the RBRVS system. The department notes that when these new rules are adopted, they will each be assigned a unique rule number, which will assist providers, insurers, and the department in making sure that the correct rule is being applied with respect to services furnished on or after the applicability date of the rule. The department believes that the adoption of the proposed new rules makes it more likely that the correct payment is made by the insurer to the provider than if the existing rules were just amended.

Finally, the department notes that it also will be drafting utilization and treatment guidelines for the various categories of health care providers, which will be formally proposed via rulemaking at a future date. Various utilization and treatment guidelines are proposed as part of this batch of rules for chiropractors, physical therapists, and occupational therapists, and carry over to a certain extent existing utilization and treatment requirements.

This general statement applies to the rules changes as indicated, with specific or additional rationales included for each rule.

4. The rules proposed to be amended provide as follows, stricken material interlined, new material underlined:

24.29.207 CONTESTED CASES (1) Except as provided in (2), parties ~~Parties~~ having a dispute involving legal rights, duties, or privileges, where the ~~dispute is one over which the department has jurisdiction to hold a hearing, must~~ bring the dispute to the department for a contested case hearing.

(2) The following disputes are required to follow the administrative rules on mediation before proceeding as provided by statute to either a contested case hearing before the department or a case in the workers' compensation court:

(a) other than disputes over benefits available directly to a claimant under Title 39, chapters 71 and 72, MCA;

(b) disputes between an insurer and a medical service provider regarding medical services provided; and

(c) disputes involving a determination of the independent contractor central unit regarding the issue of whether a worker is an independent contractor or an employee. where the dispute is one over which the department has jurisdiction to hold a hearing, must bring the dispute to the department for a contested case hearing.

~~(2)~~(3) A contested case concerning employment classifications assigned to an employer by an Plan 2 insurer is administered by the classification review committee in accordance with 33-16-1012, MCA.

~~(3)~~(4) A contested case held by the department under Title 39, chapters 71, 72 or 73, MCA, is administered by the department in accordance with ARM 24.2.101 and 24.29.201(2).

AUTH: 2-4-201, 39-71-203, ~~39-72-203~~, MCA

IMP: Title 2, chapter 6 ~~4~~, part 6, ~~33-16-1012~~, 39-71-204, 39-71-415, ~~39-71-704~~, ~~39-71-2401~~, 39-71-2905, ~~39-72-611~~, ~~39-72-612~~, MCA

REASON: There is reasonable necessity to amend ARM 24.29.207 to implement changes enacted by Chap. 117, L. 2007 (SB 108) to direct disputes between medical service providers and insurers to the mediation process effective July 1, 2007. There is also reasonable necessity to delete the reference to Title 39, chapter 72, MCA, because chapter 72 (the former Occupational Disease Act) was repealed in 2005. There is reasonable necessity to clarify that the employment classification administered by the classification review committee under the insurance commissioner's requirements in 33-16-1008, MCA, only applies to Plan 2 insurance carriers in the workers' compensation context. Finally, there is reasonable necessity to correct the rule to clarify the disputes that require mediation and to correct the implementation citations.

24.29.1404 DISPUTED MEDICAL CLAIMS (1) After mediation, disputes between an insurer and a medical service provider Disputes arising over the following issues amount of a fee for medical services are resolved by a hearing before the department upon written application of a party to the dispute or the injured worker. The following issues are considered to be disputes arising over the amount of a fee for medical services:

(a) amounts payable to medical providers, when benefits available directly to claimants are not an issue;

(b) access to medical records;

(c) timeliness of payments to medical providers; or

(d) requirements for documentation submitted by a provider to an insurer pursuant to ARM 24.29.1513 as a condition of the payment of medical fees.

(2) through (4) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-203, 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1404 to implement changes enacted by Chap. 117, L. 2007 (SB 108) directing that disputes between medical providers and insurers must first be sent to mediation before being resolved by a department hearing.

24.29.1426 HOSPITAL SERVICE RULES FOR SERVICES PROVIDED FROM APRIL 1, 1998, THROUGH DECEMBER 31, 2007 (1) through (3) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase for ARM 24.29.1426 due to Chap. 330, L. 2007 (HB 738), which is effective in relevant part on January 1, 2008, to distinguish it from rules that apply to services rendered on or after January 1, 2008. NEW RULE III is proposed to change reimbursement to a medical provider for professional services provided at a facility from the RVP to the RBRVS system. ARM 24.29.1426 will therefore apply to reimbursements for dates of service from April 1, 1998, through December 31, 2007.

24.29.1504 DEFINITIONS As used in this subchapter, the following definitions apply:

(1) "Current Procedural Terminology" or "CPT" codes means codes as published by the American Medical Association.

(1) remains the same but is renumbered (2).

(3) "Facility" or "health care facility" has the meaning provided under 50-5-101, MCA, and the administrative rules implementing that definition, and is limited to only those facilities licensed or certified by the Department of Public Health and Human Services.

(2) remains the same but is renumbered (4).

(5) "Healthcare Common Procedure Coding System" or "HCPCS" means the identification system for health care matters developed by the federal government, and includes level one codes, known as CPT codes, and level two codes that were developed to use for supplies, procedures, or services that do not have a CPT code.

(3) and (4) remain the same but are renumbered (6) and (7).

(8) "Nonfacility" means any place not included in this rule's definition of "facility".

(5) through (8) remain the same but are renumbered (9) through (12).

(13) "Relative Value Unit" or "RVU" represents a unit of measure for medical services, procedures, or supplies. RVU is used in the fee schedule formulas to calculate reimbursement fees and is expressed in numeric units. Those services

that have greater costs or value have higher RVUs than those services with lower costs or value.

(14) "Resource-Based Relative Value Scale" or "RBRVS" means the publication titled "Essential RBRVS", published by Ingenix, Inc.

(9)(15) "Treating physician" means:

(a) has the meaning provided by ARM 24.29.1511 for with respect to claims arising before July 1, 1993, and the meaning provided by 39-71-116(29), MCA (1993) for the meaning provided by ARM 24.29.1511;

(b) with respect to claims arising on or after July 1, 1993, the meaning provided by 39-71-116, MCA.

(10) remains the same but is renumbered (16).

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1504 to define RBRVS, RVU, and HCPCS, terms used in or required by Chap. 330, L. 2007 (HB 738), as those terms are not commonly understood but are an integral part of the new fee schedule proposed in NEW RULE III in this notice. The definitions of facility and nonfacility are added here in order to indicate that when the rules refer to nonfacility services, the rules refer to medical services that are provided somewhere other than a health care facility or facility, as defined by 50-5-101(23), MCA. Chap. 359, L. 2007 (SB 444) grants an advanced practice registered nurse the ability to provide services independently as a treating physician. Therefore it is necessary to amend the definition of treating physician.

24.29.1521 MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE BEFORE JANUARY 1, 2008 (1) Reimbursement for medical equipment and supplies dispensed through a medical provider before January 1, 2008, is limited to ~~the lesser of \$30.00 or 30 percent above the cost of the item including freight~~ a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either \$30.00 or 30 percent of the cost of the item, except prescription medicines are limited to charges allowed under 39-71-727, MCA. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(2) and (3) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1521 due to Chap. 330, L. 2007 (HB 738) which is effective in relevant part on January 1, 2008, to distinguish it from rules that apply to services rendered on or after January 1, 2008. NEW RULE II is proposed to change reimbursement for medical equipment and supplies to the RBRVS system. All medical equipment and supplies provided prior to January 1, 2008, are paid according to the rule in effect on the date of service so this rule is proposed to be amended to provide an ending

date. There is also reasonable necessity to clarify the amount of the reimbursement due to confusion reported to the department by users of the rule.

24.29.1532 USE OF FEE SCHEDULES FOR SERVICES PROVIDED ON OR AFTER FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) The department's schedule of fees for medical nonhospital services is known as the Montana Workers' Compensation Medical Fee Schedule. Effective July 1, 2002, to December 31, 2007, the fee schedule in this rule is hereby adopted. The fee schedule is comprised of the following:

(a) through (12) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1532 due to Chap. 330, L. 2007 (HB 738) which is effective in relevant part on January 1, 2008, to distinguish it from rules that apply to services rendered on or after January 1, 2008. NEW RULE III is proposed to adopt the RBRVS reimbursement system for medical services. All services provided prior to January 1, 2008, are paid according to the rule in effect on the date of service so this rule is proposed to be amended to provide an ending date.

24.29.1536 CONVERSION FACTORS -- METHODOLOGY FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from April 1, 1993, to December 31, 2007.

(1) and (2) remain the same but are renumbered (2) and (3).

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1536 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. The proposed rule defines the time period for which the prior method of increasing the conversion factors by the state's average weekly wage applies.

24.29.1541 ACUPUNCTURE FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) through (3) remain the same.

(4) Effective April 1, 1993, through December 31, 2007, the The following special procedure codes, with the associated description and unit values, are recognized for acupuncture specialty area services:

(a) and (b) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1541 to implement changes enacted by Chap. 330, L. 2007 (HB 738). Under the previously used RVP system, acupuncture was not covered so a separate rule was required. Under the new RBRVS system, acupuncture is now covered by proposed NEW RULE III. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1551 DENTAL SPECIALTY AREA FEES FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) through (3) remain the same.

(4) Effective April 1, 1993, through December 31, 2007, the following schedule of procedure codes, with the associated description and unit values, are recognized for the dental service areas:

(a) through (z) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1551 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Under the previously used RVP system, dental services were not covered so a separate rule was required. Under the new RBRVS system, dental services are now covered by proposed NEW RULE III. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1561 PHYSICIAN FEES -- MEDICINE FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007 (1) For services provided from April 1, 1993, through December 30, 2007, fees ~~Fees~~ for medicine specialty area services are payable according to the values listed in Relative Values for Physicians.

(2) and (3) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1561 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Under the previously used RVP system, ARM 24.29.1561 made clear that the RVP applied to standard medical nonfacility services. The proposed new RBRVS system covers all nonfacility services in NEW RULE III so a separate rule is no longer required. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1566 PHYSICIAN FEES -- ANESTHESIA SPECIALTY AREA FOR SERVICES PROVIDED FROM APRIL 1, 1993, THROUGH DECEMBER 31, 2007

(1) For services provided from April 1, 1993, through December 30, 2007, except ~~Except~~ as otherwise provided by this rule, fees for the anesthesia medical specialty area are payable according to the values listed in Relative Values for Physicians. Special unit value rules listed in ~~subsections~~ (4) and (5), ~~below~~, are established for anesthesia. Those special unit value rules supersede the corresponding unit values listed in Relative Values for Physicians, and apply to all providers. A physician who furnishes other medical services in addition to anesthesia must use the fee schedule that applies to the services rendered.

(2) through (5) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1566 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Under the previously used RVP system, ARM 24.29.1566 applied the RVP to anesthesia services and set special unit values for services. The proposed new RBRVS system covers all nonfacility services in NEW RULE III so a separate rule is no longer required. The proposed changes to this rule set an ending date for application of the rule to services provided through that date. The department will be proposing the new health care facility fee schedule in the future. The department anticipates addressing special fee schedule adjustments for anesthesia at that time.

24.29.1572 CHIROPRACTIC FEES FOR SERVICES PROVIDED ON OR AFTER FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) Beginning Effective July 1, 2002, through December 31, 2007, fees for services rendered by doctors of chiropractic are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP. The procedure codes, descriptions, and unit values in the RVP apply to diagnostic x-rays for services provided by doctors of chiropractic.

(2) through (7) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1572 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Under the previously used RVP system, ARM 24.29.1572 applied the RVP to chiropractic services and designated what codes chiropractors could bill. The proposed new RBRVS system covers all nonfacility services in NEW RULE III; however, the department believes that it is proper to continue to designate the billable codes for chiropractors. Proposed NEW RULE V copies ARM 24.29.1572 and adapts it to the RBRVS system. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1573 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR CHIROPRACTIC SERVICES PROVIDED ON OR AFTER FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from July 1, 2002, through December 31, 2007.

(1) through (12) remain the same but are renumbered (2) through (13).

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1573 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Proposed NEW RULE VI copies ARM 24.29.1573 and adapts it to the RBRVS system. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1582 PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED FROM JULY 1, 2002 THROUGH SEPTEMBER 30, 2003 (1) Effective July 1, 2002, through September 30, 2003, fees Fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below and unless otherwise specified, are payable according to the unit values listed in the RVP.

(2) through (8) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend ARM 24.29.1582 to clarify within the text of the rule that the rule only applies to services provided from July 1, 2002, through September 30, 2003.

24.29.1583 PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED BY OCCUPATIONAL THERAPISTS AND PHYSICAL THERAPISTS ON OR AFTER FROM JULY 1, 2002, THROUGH DECEMBER 31, 2007 (1) This rule applies to services provided from July 1, 2002, through December 31, 2007.

(1) through (11) remain the same but are renumbered (2) through (12).

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1583 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Proposed NEW RULE VIII copies from ARM 24.29.1583 and adapts it to the RBRVS system. The proposed changes to this rule set an ending date for application of the rule to services provided through that date.

24.29.1584 PROVIDER FEES -- OCCUPATIONAL AND PHYSICAL THERAPY SPECIALTY AREA FOR SERVICES PROVIDED ON OR AFTER FROM OCTOBER 1, 2003, THROUGH DECEMBER 31, 2007 (1) Fees for services provided by occupational therapists and physical therapists from October 1, 2003, through December 31, 2007, are payable only for the procedure codes listed below, and unless otherwise specified are payable according to the unit values listed in the RVP.

(2) through (4)(a)(iii) remain the same.

(b) Special services, procedures, and report codes 99070 and 99080 ~~At~~^{Not} ~~to be~~^{be} billed. A separate written report must be submitted describing the service provided when billing for these codes.

(5) through (8) remain the same.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to amend the catchphrase of ARM 24.29.1584 to implement changes enacted by Chap. 330, L. 2007 (HB 738), to distinguish it from rules that apply to services rendered on or after January 1, 2008. Proposed NEW RULE VII copies ARM 24.29.1584 and adapts it to the RBRVS system. The proposed changes to this rule set an ending date for application of the rule to services provided through that date. There is also reasonable necessity to correct the typo in the rule.

5. The proposed new rules provide as follows:

NEW RULE I HOSPITAL SERVICE RULES FOR CLAIMS ARISING ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services provided on or after January 1, 2008.

(2) Any overall rate change adopted by a hospital shall be reported to the department on a department-approved form before the effective date of the rate change. The department may in its discretion conduct audits of any hospital's financial records to determine proper reporting of rate change filings.

(3) Insurers shall make timely payments of hospital bills. In cases where there is no dispute over liability the insurer shall, within 30 days of receipt of a hospital's charges, either pay the charges according to the rates established by these rules, or notify the hospital that additional information is requested, and specify that information. The insurer shall then pay the charges within 30 days of receipt of the requested information.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE I to implement changes enacted by Chap. 330, L. 2007 (HB 738). Currently, a medical provider's professional fees, when the services are provided at a hospital facility, are subject to

the RVP. The legislation requires reimbursement to be based on the RBRVS system. This proposed rule is based upon ARM 24.29.1426, but deletes the reference to the RVP and the reference to professional fees because that change is proposed in NEW RULE III, deletes the reference to outpatient services as the department will be proposing rules regarding those services in a separate fee schedule, and sets a beginning date.

NEW RULE II MEDICAL EQUIPMENT AND SUPPLIES FOR DATES OF SERVICE ON OR AFTER JANUARY 1, 2008 (1) This rule applies to equipment and supplies provided on or after January 1, 2008.

(2) Except for prescription medicines as provided by ARM 24.29.1529, reimbursement for medical equipment and supplies dispensed through a medical provider is calculated by using the RVU listed in the RBRVS times the conversion factor established in [NEW RULE IV] in effect on the date of service. If a RVU is not listed or if the RVU is listed as null, reimbursement is limited to a total amount that is determined by adding the cost of the item plus the freight cost plus the lesser of either \$30.00 or 30 percent of the cost of the item. An invoice documenting the cost of the equipment or supply must be sent to the insurer upon the insurer's request.

(a) Copies of the instructions are available on the department web site at <http://erd.dli.state.mt.us/wcregs/medreg.asp> or may be obtained at no charge from the Montana Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59604-8011.

(3) If a provider adds value to medical equipment or supplies (such as by complex assembly, modification, or special fabrication), then the provider may charge a reasonable fee for those services. Merely unpacking an item is not a "value-added" service. While extensive fitting of devices may be billed for, simple fitting (such as adjusting the height of crutches) is not billable.

(4) This rule does not apply to:

- (a) health care facilities;
- (b) pharmacies; or
- (c) equipment supply houses that are not also health care providers.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE II to implement changes enacted by Chap. 330, L. 2007 (HB 738). Currently, reimbursement for medical equipment and supplies is subject to the terms of ARM 24.29.1521. The legislation requires reimbursement to be based on the RBRVS system. This proposed rule is based upon ARM 24.29.1521, but adds reimbursement pursuant to the RBRVS system, sets a beginning date, and clarifies the reimbursement amount when an RVU is not listed or is null.

NEW RULE III NONFACILITY FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) The department adopts the fee schedule provided by this rule to determine the reimbursement amounts for services provided by an individual medical service provider at a nonfacility or facility furnished

on or after January 1, 2008. An insurer is not obligated to pay more than the fee provided by the fee schedule for a service provided within the state of Montana. The fee schedule is comprised of the following elements:

- (a) the HCPCS codes, including CPT codes, which are incorporated by reference, and discussed in greater detail in (3);
- (b) the RVU given in the 2007 edition of the RBRVS, which is incorporated by reference, unless a relative value is otherwise specified in these rules;
- (c) the publication "Montana Workers' Compensation Nonfacility Fee Schedule Instruction Set for 2008", September 2007 edition, which is incorporated by reference;
- (d) the conversion factors established by the department in [NEW RULE IV];
- (e) modifiers, as found in the instructions; and
- (f) the Montana unique code, MT001, described in greater detail in (8).

(2) The conversion factors, the CPT codes, and the RVU used depends on the date the medical service, procedure, or supply is provided. The reimbursement amount is generally determined by finding the proper CPT code in the RBRVS then multiplying the RVU for that code by the conversion factor. For example, if the conversion factor is \$5.00, and a procedure code has a unit value of 3.0, the most that the insurer is required to pay the provider for that procedure is \$15.00.

(3) Unless a special code or description is otherwise provided by rule, pursuant to 39-71-704, MCA, the edition of the CPT publication in effect at the time the medical service is furnished must be used to determine the proper procedure code.

(4) Instructions for the fee schedule are available on the department's web site, along with already calculated reimbursement amounts by CPT code. All the definitions, guidelines, RVUs, procedure codes, modifiers, and other explanations provided in the instructions affecting the determination of individual fees apply. A copy of the instructions is available on the department web site at <http://erd.dli.state.mt.us/wcregs/medreg.asp> or may be obtained at no charge from the Montana Department of Labor and Industry, P.O. Box 8011, Helena, Montana 59604-8011.

(5) The maximum fee that an insurer is required to pay for a particular procedure is listed on the department web site and was computed using the RVU in the total facility or nonfacility column of the RBRVS times the conversion factor, except as otherwise provided for in these rules.

(6) Each provider is to limit services to those which can be performed within the limits and restrictions of the provider's professional licensure. For nonlicensed providers, the insurer is not required to reimburse above the related CPT codes for appropriate services.

(7) RVUs have not been established in the RBRVS for CPT codes 99455 and 99456. The RVU established by the department for:

- (a) code 99455 is 2.5 RVU; and
- (b) code 99456 is 2.8 RVU.

(8) When billing the services listed below, the Montana unique code, MT001, must be used and a separate written report is required describing the services provided. The reimbursement rate for this code is 0.5 RVUs per 15 minutes. These requirements apply to the following services:

(a) face-to-face conferences with payor representative(s) to update the status of a patient upon request of the payor;

(b) a report associated with nonphysician conferences required by the payor;
or

(c) completion of a job description or job analysis form requested by the payor.

(9) Where a procedure is not covered by these rules, the insurer must pay a reasonable fee, not to exceed the usual and customary fee charged by the provider to nonworkers' compensation patients unless the procedure is not allowed by these rules.

(10) Where a service is listed as "by report", the fee charged may not exceed the usual and customary fee charged by the provider to nonworkers' compensation patients.

(11) It is the responsibility of the provider to use the proper procedure, service, and supply codes on any bills submitted for payment. The failure of a provider to do so, however, does not relieve the insurer's obligation to pay the bill, but it may justify delays in payment until proper coding of the services provided is received by the insurer.

(12) Copies of the RBRVS are available from the publisher. Ordering information may be obtained from the department at the address listed in (4).

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE III to implement changes enacted by Chap. 330, L. 2007 (HB 738). Currently, reimbursement for nonfacility medical services is subject to the RVP. The legislation requires reimbursement to be based on the RBRVS system. This proposed rule is based upon ARM 24.29.1532, but deletes references to the RVP, adds reimbursement pursuant to the RBRVS system, incorporates department instructions and conversion factors, makes the rule easier to read for users, and sets a beginning date.

CPT codes 99455 and 99456 have been used in the Montana workers' compensation fee schedules applicable before January 1, 2008, and their RVU values were based on values from the RVU system. These codes do not have RVUs in the RBRVS. The department is proposing to establish values for these codes in the nonfacility fee schedule.

In addition, under the fee schedules for the previous years and under the RVP system, code 97799 applied only to chiropractors, occupational therapists, and physical therapists, and allowed billing for payor conferences. There is no equivalent code in the RBRVS system. The department is proposing to apply the substance of this code to all medical providers. A new Montana unique code, MT001, is being proposed to allow all providers to be reimbursed for these services.

NEW RULE IV CONVERSION FACTORS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 -- METHODOLOGY (1) This rule applies to services, supplies, and equipment provided on or after January 1, 2008.

(2) The conversion factors are established annually by the department pursuant to 39-71-704, MCA. The conversion factor for goods and services, other than anesthesia services:

(a) provided on or after January 1, 2008, is \$63.45.

(3) The conversion factors are established annually by the department pursuant to 39-71-704, MCA. The conversion factor for anesthesia services:

(a) provided on or after January 1, 2008, is \$57.20.

(4) The top five insurers or third-party administrators, ranked by premiums written in Montana providing group health insurance coverage through a group health plan as defined in 33-22-140, MCA, and who use the RBRVS to determine fees for covered services, must annually provide to the department their current standard conversion factors by July 1.

(5) The conversion factor amounts for nonfacility services are calculated using the average rates for medical services paid by the top five insurers or third-party administrators providing group health insurance via a group health plan in Montana, based upon the amount of premium for that category of insurance reported to the office of the Montana insurance commissioner. The term "group health plan" has the same meaning as provided by 33-22-140, MCA.

(a) The department annually surveys the top five insurers to collect information on the rates (the RBRVS conversion factors) paid during the current year for nonfacility health care services furnished in Montana.

(b) The department's conversion factors for the following year are set at 110% of the surveyed average.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE IV to implement changes enacted by Chap. 330, L. 2007 (HB 738). This legislation bases the annual calculation of the conversion factors at a rate not higher than 10% above the average of the conversion factors used by the top five insurers or third-party administrators providing disability insurance who use the RBRVS system. This proposed rule clarifies that, within the broad category of disability insurance covered by Title 33, chapter 22, MCA, the department will only use the conversion factors of insurers or third-party administrators who provide group health insurance in Montana because those entities make up the private insurance market that is comparable to the coverage provided by workers' compensation insurance. There is reasonable necessity to actually establish the dollar amount of the conversion factors that will be applied beginning January 1, 2008, as well as to describe the methodology for how the conversion factors are established. The department notes that the system establishing two nonfacility conversion factors, one for anesthesia services and another for all goods and services other than anesthesia services, is dictated by the design of the RBRVS system.

NEW RULE V CHIROPRACTIC FEE SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services that are provided on or after January 1, 2008.

(2) Fees for services rendered by doctors of chiropractic are payable only for the procedure codes listed below and, unless otherwise specified, are payable according to the amounts allowed by the nonfacility fee schedule. The reimbursement rates referenced in the nonfacility fee schedule apply to diagnostic x-rays for services provided by doctors of chiropractic.

(3) Only the following codes may be billed for chiropractic services:

(a) all physical medicine and rehabilitation codes except:

(i) codes 97001 through 97006;

(ii) code 97033;

(iii) code 97532;

(iv) code 97533; and

(v) codes 97810 through 97814;

(b) special services, procedures, and report codes 99070, 99080, and MT001. Code MT001 is described in [NEW RULE III]. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection;

(c) chiropractic manipulative treatment codes 98940 through 98943;

(d) evaluation and management codes 99201 through 99204 and 99211 through 99214; and

(e) all diagnostic x-ray codes. The provider must furnish to the insurer documentation of the reasons justifying the use of the diagnostic x-ray procedure(s) employed.

(4) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the nonfacility fee schedule are applied to the procedure codes contained in this rule.

(5) Code 97750 is payable for a maximum of 24 15-minute increments of service per day.

(6) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of a chiropractor. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.

(7) When a chiropractor is performing orthotics fitting and training (code 97760) or checking for orthotic/prosthetic use (code 97762), supplies and materials provided may be billed separately for each visit using the appropriate HCPCS code.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE V to implement changes enacted by Chap. 330, L. 2007 (HB 738). In addition to adopting the RBRVS system, this legislation allows the department to adopt utilization and treatment guidelines. This proposed rule is based upon ARM 24.29.1572, but adds a beginning date and changes from the RVP to the nonfacility fee schedule in NEW RULE III which incorporates the RBRVS. In addition, the rule continues the utilization and treatment guidelines that were established under ARM 24.29.1572. Proposed NEW RULE V also removes CPT codes that are obsolete and replaces

them with current codes. To improve the rules for the users, the proposed rule copies the language regarding billing for group treatment from ARM 24.29.1573. Also, code 97799 is removed and replaced by MT001. The substantive requirements of this new code are moved to NEW RULE III, so that it applies to all providers.

NEW RULE VI CHIROPRACTIC -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

- (1) This rule applies to services that are provided on or after January 1, 2008.
- (2) Evaluations and re-evaluations may not be billed more than once every 30 days without prior authorization. For the first visit and for each 30-day evaluation, the chiropractor may charge for an office call in addition to treatment codes. For all other visits, the provider may charge only treatment codes without prior authorization.
- (3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750.
 - (a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical RVU has not been established, require prior authorization from the insurer.
- (4) No more than two 15-minute units per day may be billed for each code 97032, 97034, and 97035 without prior authorization. When ultrasound (code 97035) and electrical stimulation (code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.
- (5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.
- (6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.
- (7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.
- (8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.
- (9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750, each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.
- (10) When billing for a manipulative treatment using codes 98940, 98941, 98942, or 98943, an office visit may be charged for the treatment without prior authorization only if a modifier 25 is used for a specific evaluation and management code.
- (11) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the chiropractor's office. Mileage and travel expenses shall be established with the insurer during prior authorization.
- (12) See ARM 24.29.1517 for additional prior authorization requirements concerning health care services provided by chiropractors.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE VI to implement changes enacted by Chap. 330, L. 2007 (HB 738). This proposed rule is based upon ARM 24.29.1573, but adds a beginning date and changes from the RVP to the new fee schedule, which incorporates the RBRVS.

NEW RULE VII OCCUPATIONAL AND PHYSICAL THERAPY FEE
SCHEDULE FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008

- (1) This rule applies to services that are provided on or after January 1, 2008.
- (2) Fees for services provided by occupational therapists and physical therapists are payable only for the procedure codes listed below and, unless otherwise specified, are payable according to the amounts allowed by the nonfacility fee schedule.
- (3) Only the following codes found in the nonfacility fee schedule may be billed for services provided by occupational therapists and physical therapists:
 - (a) all physical medicine and rehabilitation codes, except:
 - (i) 97532;
 - (ii) 97533; and
 - (iii) 97810 through 97814; and
 - (b) special services, procedures, and report codes 99070, 99080, and MT001. Code MT001 is described in [NEW RULE III]. A separate written report must be submitted describing the service provided when billing for the codes identified in this subsection.
- (4) The explanations, protocols, comments, and directions for use contained in both the CPT manual and the nonfacility fee schedule are to be applied to the procedure codes contained in this rule.
- (5) When billing code 97033 (iontophoresis), medication charges and electrode charges must each be billed separately for each visit using code 99070.
- (6) Code 97150 is to be used when two or more injured workers are being treated in a group setting and all participants are engaged in the same therapeutic procedures under the direct supervision of the treating therapist. Documentation indicating the type of treatment and the number of participants in each session must be provided along with each bill.
- (7) When an occupational therapist or a physical therapist is performing orthotics fitting and training (code 97760) or checking for orthotic/prosthetic use (code 97762), supplies and materials provided may be billed separately for each visit using the appropriate HCPCS code.

AUTH: 39-71-203, MCA
IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE VII to implement changes enacted by Chap. 330, L. 2007 (HB 738). This proposed rule is based upon ARM 24.29.1584, but adds a beginning date, changes from the RVP to the fee

schedule which incorporates the RBRVS, and makes minor changes to make the rule more concise. In addition to adopting the RBRVS system, the legislation allows the department to adopt utilization and treatment guidelines. This proposed rule continues the utilization and treatment guidelines that were established under ARM 24.29.1584. Proposed NEW RULE VII also removes CPT codes that are obsolete and replaces them with current codes. To improve the rules for users, the proposed rule copies the language regarding billing for group treatment from ARM 24.29.1583. Also, code 97799 is removed and replaced by MT001. The substantive requirements of this new code are moved to NEW RULE III, so that it applies to all providers.

NEW RULE VIII OCCUPATIONAL AND PHYSICAL THERAPISTS -- PRIOR AUTHORIZATION AND BILLING LIMITATIONS FOR SERVICES PROVIDED ON OR AFTER JANUARY 1, 2008 (1) This rule applies to services that are provided on or after January 1, 2008.

(2) Examinations and re-examinations may not be billed more than once every 30 days without prior authorization unless physician ordered. For the first visit and for each 30-day examination, the occupational therapist and physical therapist may charge for an office call in addition to treatment codes. For all other visits, the occupational therapist and physical therapist may charge only treatment codes without prior authorization. All examinations and re-examinations require a written report separate from the daily treatment note that reflects the claimant's functional status.

(3) Prior authorization is required before performing the procedures identified by codes 97535, 97537, 97545, 97546, and 97750.

(a) New procedures, for which a CPT code does not yet exist, and those procedures for which a numerical RVU has not been established, require prior authorization from the insurer.

(4) No more than two 15-minute units per day may be billed for each CPT code 97032, 97034, and 97035 without prior authorization. When ultrasound (CPT code 97035) and electrical stimulation (CPT code 97032) are used simultaneously in treatment, only the higher unit value of the two may be billed without prior authorization.

(5) Procedure codes 97110, 97112, 97113, 97116, 97140, 97530, 97532, 97533, and 97542, when billed alone, can be billed for no more than four 15-minute units in one day without prior authorization.

(6) Procedure code 97124, when billed alone, can be billed for no more than three 15-minute units in one day without prior authorization.

(7) No more than three unattended modality codes (97010 through 97028) may be billed each visit without prior authorization.

(8) If the patient's condition requires the use of unattended modalities only, no more than three unattended modalities (codes 97010 through 97028) may be billed per visit. Unattended modalities in the absence of any other treatment may not be billed for a period exceeding two calendar weeks without prior authorization.

(9) No more than a total of five codes may be billed per visit without prior authorization. With the exception of codes 97535, 97537, 97545, 97546, and 97750,

each 15 minutes of a timed code is equivalent to the billing of one code for purposes of this rule.

(10) Code 97535 is to be used when training is conducted in the injured worker's home or at some other location outside of the therapist's office. Mileage and travel expenses shall be established with the insurer during prior authorization.

(11) See ARM 24.29.1517 for additional prior authorization requirements concerning medical services provided by occupational therapists and physical therapists.

AUTH: 39-71-203, MCA

IMP: 39-71-704, MCA

REASON: There is reasonable necessity to adopt NEW RULE VIII to implement changes enacted by Chap. 330, L. 2007 (HB 738). This proposed rule is based upon ARM 24.29.1583, but adds a beginning date, changes from the RVP to the new fee schedule which incorporates the RBRVS, and removes chiropractors from the language of the rule.

6. A copy of the proposed 2008 instruction set publication, identified in NEW RULE III, is available and can be accessed on-line via the internet at: <http://erd.dli.state.mt.us/wcregs/medreg.asp>. A printed version of the proposed 2008 publication is also available by contacting Jeanne Johns, at the address or telephone numbers listed in paragraph 2.

7. Concerned persons may present their data, views, or arguments, either orally or in writing, at the hearing. Written data, views, or arguments may also be submitted to: Jeanne Johns, Workers' Compensation Regulation Section Supervisor, Workers' Compensation Regulation Bureau, Employment Relations Division, Department of Labor and Industry, P.O. Box 8011, Helena, MT 59624-8011; by facsimile to (406) 444-7710; or by e-mail to jjohns@mt.gov, and must be received no later than 5:00 p.m., October 5, 2007.

8. An electronic copy of this Notice of Public Hearing is available through the department's web site at <http://dli.mt.gov/events/calendar.asp>, under the Calendar of Events, Administrative Rules Hearings Section. The department strives to make the electronic copy of this Notice of Public Hearing conform to the official version of the Notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the Notice and the electronic version of the Notice, only the official printed text will be considered. In addition, although the department strives to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems, and that a person's difficulties in sending an e-mail do not excuse late submission of comments.

9. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have

their name added to the list shall make a written request, which includes the name and mailing address of the person to receive notices and specifies that the person wishes to receive notices regarding all Department of Labor and Industry administrative rulemaking proceedings or other administrative proceedings. Such written request may be mailed or delivered to the Department of Labor and Industry, attention: Mark Cadwallader, 1327 Lockey Avenue, P.O. Box 1728, Helena, Montana 59624-1728, faxed to the department at (406) 444-1394, e-mailed to mcadwallader@mt.gov, or may be made by completing a request form at any rules hearing held by the agency.

10. The bill sponsor notice requirements of 2-4-302, MCA, apply and have been fulfilled. The primary sponsor of House Bill 738 was notified on May 17, 2007, by regular mail. The primary sponsor of Senate Bill 108 was notified on May 17, 2007, by regular mail. The primary sponsor of Senate Bill 444 was notified on August 22, 2007, by regular mail.

11. The department's Hearings Bureau has been designated to preside over and conduct this hearing.

/s/ MARK CADWALLADER

Mark Cadwallader
Alternate Rule Reviewer

/s/ KEITH KELLY

Keith Kelly, Commissioner
DEPARTMENT OF LABOR AND INDUSTRY

Certified to the Secretary of State August 27, 2007